PRINTED: 01/28/2010
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN8901	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, MCMINNVILLE	928 OLD SMITHVILLE RD MC MINNVILLE, TN 37110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 901	1200-8-6-.09(1) Life Safety (1) Any nursing home which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Rule is not met as evidenced by: 'N' TAG Based on observation during the survey on 1/26/10, it was determined, the facility failed to maintain the electrical system. The findings included: At 10:50 AM observation within the resident room # 400, observation revealed the light fixture was without lens cover. Tennessee Department Of Health (TNDOH) 1200-8-6-08(1). The findings were noted by the Maintenance Director, verified and acknowledged by the facility administrator during the exit interview on 1/26/10.	N 901	N901 Light cover was replaced by Maintenance Supervisor on 1/26/2010. Maintenance Supervisor and Maintenance Assistant will check light covers monthly for three months and then quarterly for nine months to ensure continued compliance. Findings will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing). **Completion date:**	1/26/2010

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2-12-2010

STATE FORM 6899 VI5B21 If continuation sheet 1 of 1